St Bernadette's Primary School Lalor Park

Notification and Request by Parent / Guardian for the Administration of Medication during school hours

I request that my child _____ be allowed to take medication at school
insert full name of student

according to instructions from _____.
full name of prescribing doctor

Address of prescribing doctor (if applicable) _____
_____
_____

Contact Number: _____

The medication has been prescribed for the following reason:
_____
_____
_____

Amount of medicine to be administered _____
What time is your child to take the medicine _____
How many days is the medicine to be administered _____

I hereby give permission to the Principal / Secretary to administer the above medication and if necessary to obtain relevant information from the prescribing doctor.

I accept and agree to observe the conditions imposed by the school and understand and agree that it is my responsibility to inform the Principal / Secretary of any changes involving administration of the medicine.

Signed ……... Date …….
(parent / guardian)